Public Employees Benefits Board (PEBB)

2004 Self-Pay Medical and Dental Coverage

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- All covered family members must be included on this form.
- Make checks payable to the State Treasurer.

SECTION 1: Subscriber Information

Date employer coverage ended

Social security number | Sex ❑ M ❑ F | Last name | First name | Middle initial

Address | Apt./unit number

City | State | ZIP Code | County of residence

Date of birth (mm/dd/yyyy) | Work phone number (including area code) | Home phone number (including area code)

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their preferred providers and require you to choose a primary care provider. **Contact your plan for code.** ➡ Physician or clinic code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only ❑ Life insurance

Are you part-time faculty? ❑ Yes ❑ No

Reason for self-pay: ❑ Leave without pay ❑ Reduction in force ❑ Family Medical Leave Act ❑ Educational leave ❑ Other

SECTION 2: Family Member Information

List only eligible family members you wish to cover.

Relationship to subscriber
❑ **Spouse** OR ❑ **Same-sex domestic partner**

Social security number | Physician or clinic code (contact plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

Other Family Members (such as child, grandchild, etc.) Use additional forms for more members

A **Relationship to subscriber** | ❑ Disabled? ❑ Student? *Check only if age 20 or older.* | Sex ❑ M ❑ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

B **Relationship to subscriber** | ❑ Disabled? ❑ Student? *Check only if age 20 or older.* | Sex ❑ M ❑ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

SECTION 3: Changes

(Check all that apply.)

Subscriber changed: ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan

I wish to cancel **medical** coverage. ❑ Yes ❑ No

I wish to cancel **dental** coverage. ❑ Yes ❑ No

Change in family status:

❑ **Adding a spouse or same-sex domestic partner.** You **must** complete a Declaration, available from the Health Care Authority or online at www.pebb.hca.wa.gov

❑ **Adding family member A**

❑ **Adding family member B**

❑ **Widowed** Date (mm/dd/yyyy)_____

❑ **Removing a spouse or same-sex domestic partner from coverage.** Please provide his/her new address, date of event, and reason:

Address _____

_____

Date (mm/dd/yyyy) _____

Reason _____

❑ **Removing other family members from coverage**

Name _____

Date (mm/dd/yyyy) _____

SECTION 4: Medical Plan Selection

(Check only one.)

❑ Community Health Plan of Washington

❑ Group Health Cooperative

❑ Group Health Options, Inc.

❑ Kaiser Foundation Health Plan of the Northwest

❑ PacifiCare of Washington, Inc.*

❑ RegenceCare*

❑ Uniform Medical Plan Preferred Provider Organization

** These plans require the physician or clinic code of your selected primary care provider. Contact plan for code or go online to* **www.pebb.hca.wa.gov** *for provider directories.*

SECTION 5: Dental Plan Selection

(Check only one.)

Preferred Provider Organization

❑ Uniform Dental Plan (Group #3000)
(may receive services *from any provider*)

Managed Care Plans

❑ DeltaCare (Group #3100)
Dentist name _____
(must receive services from *DeltaCare provider*)

❑ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

SECTION 6: Life Insurance

Current Enrollment with Agency	Coverage Amount
☒ Basic Part A ($ x / month)	$25,000
❑ Part B–Dependent/Children	
❑ Part B–Spouse	
❑ Part B–Supplemental Spouse	_____
❑ Part C	_____
❑ Part D	_____
❑ Part E with Dependents	_____
❑ Part E without Dependents	_____

Desired Enrollment while Self-Paying

❑ I wish to maintain the same coverage I had as an active employee. _____ ***(initials)***

❑ I do not wish to continue the life coverage while eligible for self-pay, and **I understand that I must reapply and submit evidence of good health to reinstate optional life insurance when I return to work.** _____ ***(initials)***

SECTION 7: Long-Term Disability

*This section applies **ONLY** to employees on **educational leave.***

Current Enrollment with Agency

❑ Basic

☒ 30-Day ❑ 120-Day ❑ 300-Day

❑ 60-Day ❑ 180-Day ❑ 360-Day

❑ 90-Day ❑ 240-Day

Desired Enrollment while Self-Paying

❑ I wish to maintain the same coverage I had as an active employee. _____ ***(initials)***

❑ I do not wish to continue the long-term disability while eligible for self-pay. _____ ***(initials)***

SECTION 8: Signature (Required)

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority. I declare that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

_____

Subscriber's signature Date

Please sign and date this form.

Return to: Washington State Health Care Authority
P.O. Box 42684, Olympia, WA 98504-2684

If payment enclosed, return to:
Washington State Health Care Authority
P.O. Box 42695, Olympia, WA 98504-2695

Washington State Health Care Authority
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Visit our Website at www.pebb.hca.wa.gov